CLIENT INTAKE FORM

Welcome to Epiphanye Counseling Services! I look forward to providing you with quality and effective services. Please provide the following information and answer the questions below. The information you provide will help me to understand your situation and help me best help you. Please note that the information you provide on this form is confidential.

Today's Date: _____

Type of Services being sought (check all that apply):

□ Individual □ Couple/Marital □ Family □ Group

Referred by: _____

General Information:

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (If under the age of 18)

_____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: Gender: □ Male □ Female

Marital Status:

□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Address:_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: _____ May we leave a message? □Yes □ No
May we identify ourselves as ECS? □Yes □ No

Cell/Other Phone:_____ May we leave a message? □Yes □ No
May we identify ourselves as ECS? □Yes □ No

E-mail: _____ May we send you our newsletter? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication. ECS has secure email for those who would like to communicate through email.

Would you like appointment E-mail reminders? □Yes □ No

May we send material/information to your home? □ Yes □No

May we follow-up after discharge of services? □ Yes □No

Please provide a security question and answer to transmit sensitive information securely via email_____

Emergency Contact

Name: _____ Rel. to Client_____

Phone: _____

Names of individuals living in Household:

Last, First Name	Relation to Client	Age/Birth Date	Highest Grade Completed

What is your annual household income (for clients using sliding fee scale rate)? _____

What are your primary concerns that bring you here?

1. _____
2. _____
3. _____

What are your goals for counseling?

1. _____
2. _____
3. _____

What is your primary language? _____

Race: _____

Cultural
Considerations_____

Religion: _____

What special accommodations do you need (if applicable) _____

_____

Mental Health and Social History

Have you previously received any type of mental health services (Psychotherapy, Psychologist, Psychiatric services.)? No□ If yes, please indicate the problem/condition and dates of treatment:
_____

_____

_____

Are you currently taking any prescription medications? Yes □ No □ If yes, Please list:
_____

_____

Are you currently taking prescribed psychiatric medications? Yes □ No □ If yes, please list:

_____

Have you been previously prescribed psychiatric medication? Yes □ No □ If yes, please list:

_____

Have you had any suicidal/homicidal thoughts/attempts? Yes □ No □ If yes, please describe:

_____

_____

Have you engaged in self-injurious behavior(s)? Yes □ No □ If Yes, please describe:

_____
_____
_____

Medical and Health History

Primary Physician:

_____

Primary Physicians Address:

_____

Primary Physicians Phone: _____Date of Last Exam_____

Please List Allergies (if any) _____

_____

Is it okay to contact your primary physician to coordinate services and provide you with quality and effective care? Yes □ No □

How would you rate your current physical health? (Please check)

Poor □ Satisfactory □ Good □ Excellent □

Please list any specific health problems you are currently experiencing: _____
_____
_____

Substance Abuse

Have you had any trouble with alcohol or other substances? Yes □ No □ if yes, please explain:

_____

_____

Abuse History

Have you experienced physical, sexual or emotional abuse? Yes □ No □ If yes, please explain:

_____
_____

Family Mental & Health History

Has anyone in the family attended therapy previously or is currently in treatment? Yes □ No □ If yes, please explain:

Name Reason for Treatment Dates of treatment

_____

_____

_____

Has anyone in the family have suicidal thoughts/attempts? Or engage in self-injurious behaviors? Yes □ No □ if yes, please explain:

Name Type of problem Dates of treatment

_____

_____

_____

Has anyone in the family been a victim or perpetrator of child/elder abuse (physical, sexual, emotional, neglect), domestic violence, rape or related violent behaviors? Yes □ No □ if yes, please explain:

Name Type of abuse/trauma Dates of treatment

_____

_____

_____

Has anyone in the family have or been involved with the legal system (probation, jail, prison, DUI etc.)? Yes □ No □ if yes, please explain:

Name Reason Dates of treatment

_____

_____

_____

Is or has anyone in the family being treated for a medical problem(s) and/or disability?

Name Condition Dates of treatment

_____

_____

Personal Strengths, Interests and Relationships

What are your strengths ?

Please list your support system(s)?

List any groups, hobbies, interests:

Are you currently in a relationship? _____

If yes, for how long?_____

On a scale of 1-10 how would you rate your relationship? _____

What significant life changes or stressful events have you experienced recently?_____

Describe your relationship with:

Parents:_____

Siblings:_____

Extended Family Members

Spouse/Significant Other:

_____

_____

Children:

_____

_____

Legal History

Do you have a history of any legal charges? Yes □ No □ If yes, please explain:

_____

_____

_____

Are you currently on probation or parole? Yes □ No □ If yes, please explain_____

_____

_____

Is treatment court ordered? Yes □ No □ If yes, please describe: _____

_____

_____

Employment

Are you currently employed? Yes □ No □ If yes, what is your current employment situation?

_____

_____

Please list any work-related stressors, if any: _____

_____

Is there anything else that you would like me to know? Please explain

_____

_____

Thank you for taking the time to complete this form!